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Diseases of Infants and Children.

OWNER:
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PEDIATRICS

Vol. II. OCTOBER 1st, 1896. No. 7.

Original Articles.

AUSTRALIAN ENTERICA.

By Angel Money, M.D., F.R.C.P., Lond.,
Sydney, N. S. W.

A RECENT epidemic, during which at least fifty cases of enterica have passed—happily without any death—through the wards of the Hospital for Sick Children, Sydney, N. S. W., affords an opportunity of examining the assertion that Australian enterica is a very different disease from the European variety. One item of difference may at least be conceded: that diarrhœa is seldom a symptom of any severity. But I am far from thinking that there is such a very marked contrast between the Colonial and the European fevers. So far as brain symptoms go, in respect of the temperature chart, the state of the tongue, spleen, lungs and heart, my observations have not detected any extraordinary contrast. Even with regard to the state of the bowels my experience in Sydney affords at least three cases in which diarrhœa was a pronounced symptom, lasting more than a week and requiring energetic treatment; in two of these an autopsy proved conclusively the correctness of the diagnosis; and in both these cases the large bowel was abundantly affected with ulcers; which is interesting because opposed to the view that constipation may be an expression of the presence of ulceration in the large bowel. Dr. Scot-Skirving, in the *Australasian Medical Gazette*, states, "One of the peculiarities of enteric fever in Australia is the absence of the looseness of the bowel, so common in Europe;" surely too sweeping a

statement. Certainly in the old country inaction of bowel throughout the greater part of the illness is of very frequent occurrence. Further, the percentage of cases of European enterica exhibiting excessive action is, according to some statistics, not quite so great as the percentage presenting constipation. The conclusion at which I have arrived is, that though there may be minor differences between the bulk of Australian and the majority of European cases, these differences are rather of degree than of kind, and possibly the degree of severity of the fever may account for the most noticeable of them.

Tympanites was not a very marked symptom in the majority of cases of enterica in the Hospital for Sick Children; in only three cases in which it was present in great degree there was extensive respiratory trouble; the breathing being very frequent; the lips decidedly blue; and much bronchitic râle with some hypostatic congestion being present. Two of these three cases had a most remarkably glazed tongue, which persisted for more than a week after the temperature had become normal; in both, also, the degree of anemia was uncommon. In all three cases constipation was conspicuous throughout the febrile process, and was a very troublesome symptom during convalescence. The proposition has been suggested to me by the cases observed as to whether there is not some relationship between special nervous symptoms and constipation. Reference is made to an exceedingly high temperature occurring as an eventful episode in the midst of considerable pyrexia; to a fine tremor; and to the occurrence of a combination of symtoms which may fairly be described as *pseudo-meningitis*. The hyperpyrexia occurred in three cases; in each the temperature rose to above 106°, and required the free use of the cold bath to repress it; this tendency did not last more than three days; it occurred in all three cases during the third period of the fever; in only one was there a recurrence of hyperpyrexia; the ages of the three cases were from five to nine years. The fine tremor—like that due to mercury—occurred in a female child aged five years; it was bilaterally symmetrical in the hands and face, something very different to the subsultus tendinum of the typhoid state; the child was very ill with very dry tongue; semistupor and constipation for the most part; though for a few days diarrhœa had to be controlled by medicaments. In several cases a marked tache cerebrale was noted. In the child which had the tremor an erythema, affecting the forearms, front and back, lasting for three days, was observed three times; once pending a relapse of the fever, and twice subsequently during convalescence. In all cases the knee jerk appeared to be exaggerated; in none was it lost.

A PECULIARITY IN THE SHAPE OF THE HAND IN IDIOTS OF THE "MONGOL" TYPE.

By T. Telford Smith, M.A., M.D.,

Medical Superintendent, Royal Albert Asylum, Lancaster.

IDIOTS of the Mongol type are so called from their remarkable facial resemblance to the Mongol branch of the human family, a resemblance pointed out by Dr. Langdon-Down in 1866.

They form a well marked and characteristic group with many points of similarity both in physical constitution and appearance, as well as in mental capacity and disposition. In fact, as Dr. Langdon-Down says, "so marked is this that, when placed side by side, it is difficult to believe that the specimens compared are not children of the same parents."*

Their condition is invariably congenital.

Numerically they form a group which Dr. Shuttleworth estimates at about five per cent. of mentally-defective children.†

The following brief description sums up the most constant of the physical and mental peculiarities which are found in cases of this type:

They are undersized in stature. The face is broad, flat, and round, the eyes being as a rule obliquely placed, with a narrow palpebral fissure; the width between the internal canthi is generally greater than normal, and an epicanthic fold is often present. Tarsal ophthalmia is very common. The nose is small and rather flattened. The ears are small and badly shaped, the lobules are adherent.

The mouth is generally open, and the lips are sometimes fissured and thick.

The tongue is characteristic and invariable—it is very rough, and is traversed by deep fissures, both conditions being due to the papilla being markedly hypertrophied. The tongue is often long and pointed.

The palate varies, but generally it is rather higher than normal, this condition, however, being exaggerated in appearance by the almost invariable thickening and hypertrophy of the gums all round the alveolar curve on the inner aspect. The

*London Hospital Reports 1866.

†"Mentally-Deficient Children."—Shuttleworth.

FIG. 1. Mongol Idiots.

FIG. 2. Casts of Hands of Mongol Idiots, showing curve of little finger.

Fig. 3. Skiagraph of Mongol Hand.

alveolar curve itself is, as a rule, fairly good, but the teeth are irregular and carious. Both first and second dentition are delayed.

Their skin is coarse, dry, and scaly; and the hair is dry, thin, and straight.

Their circulation is sluggish, and their temperature is generally subnormal. In cold weather they show a tendency to chilblains and catarrhs. Cold also depresses their mental powers.

Their joints are remarkably lax. Many of them show a peculiar fondness for squatting with the legs crossed under them in oriental fashion.

The general shape of their hands and feet is short and thick, with fingers and toes below the normal in length.

The shape of the head is almost invariable. It is markedly brachycephalic, the circumferential contour approaching a circle. The plane of the face and the plane of the occiput tend to parallelism.

The skull is generally much thinner than normal.

The convolutional anatomy of the brain is remarkably simple, the primary convolutions are broad and large, secondary convolutions being few or absent.

Dr. A. W. Wilmarth after an examination of five brains of Mongol idiots writes as follows: "In all these the brains are of good size for imbecile brains, the pons and medulla alone being very small, weighing in each case about one-half ounce, whereas the usual weight is nearly twice as much."

"From the small size of the pons and medulla in every instance, there seems to be a strong probability that the low nutrition, and possibly the other anatomical peculiarities of this group, may be due to the imperfect development or absence of certain cell-groups in this region."*

Mentally the Mongol idiots resemble each other to a marked degree. Their mental reflexes are slow. Their speech is thick and guttural, and their vocabulary is very limited. They are fond of music, and have a good idea of rhythm and time. They are observant, and their power of mimicry is remarkable. Of number they have little idea.

In disposition they are affectionate and friendly, and, as a rule, they are clean and orderly in their habits.

*"Report on the Examination of 100 Brains of Feeble-minded Children."—A. W. Wilmarth, M.D., Elwyn, Pa.

The etiology of this type of idiocy is not yet fully investigated. That the embryo commences existence with a lack of initial vital energy from either the paternal or maternal side, or both, is almost certain. This may be due to various causes acting on one, or both, progenitor, most frequently I think on the maternal side. Among the most frequent of these causes may be mentioned a family history of tuberculosis, immature or senile marriages, considerable inequality in the ages of parents, an exhausted condition of mother from rapid and numerous pregnancies, or from ill-health, or great mental worry.

This deficiency of initial vital energy is manifest throughout the whole life of idiots of this type, as shown by their general want of tone, and their marked tendency to degenerative diseases of a tubercular type. They almost invariably fall a prey to the tubercle bacillus before they pass the period of puberty. As Dr. Shuttleworth aptly expresses it, "There is reason to believe that they are essentially unfinished children, and that their peculiar appearance is really that of a phase of fœtal life."*

The peculiarity in the shape of the hand, to which I wish to call attention, exists in the little finger and consists in a marked outward bowing or curve of this finger. This curve is fairly well shown in the accompanying reproduction from a photograph of casts of two Mongol hands. The two boys from whose hands the casts were taken are shown in the group. The skiagraph† was taken from the hand of the boy on the left in the group. From it we see that the second phalanx of the little finger is considerably shorter than normal, and there is much lateral displacement of the terminal phalanx. This curve of the little finger occurs to a greater or less degree in nearly every case of Mongol idiocy I have examined, so that I think it may almost be looked upon as one of the constant peculiarities of this type. The degree of the curve is not in proportion to the degree of idiocy of the case, it seems to vary in each.

As to the etiology or morphology of the curve I can give no account, but it is so constant that one is inclined to the opinion that there must be some developmental basis for it. That it is one of the features of their generally unfinished condition seems probable.

*"Mentally-Deficient Children."— Shuttleworth.

†The skiagraph was kindly taken for me by Dr. A. Schloesser of the Storey Institute, Lancaster.

TWO CASES OF NOMA.

By J. H. Huddleston, M.D.,
New York,
Chief of Clinic, Bellevue Medical School.

THE first case was at the New York Dispensary in the Italian class of Dr. R. K. Macalester, and to him I am indebted for the history; the second was in my own service at the Gouverneur Hospital.

Case 1.—Francesca Rienza, three years of age, was born in the United States of Italian parentage.

The parents and two sisters were living and healthy. During the first year of life, the patient had eczema for seven or eight months, and after that the father noticed a large and hard tumor at the site of the spleen. There was no specific history. The child ate heartily and of everything.

Three days before the first visit to the dispensary, the parents noticed a small black spot, the size of a pea, inside the lower lip, and at this the child kept picking; the next day a black spot corresponding to the place inside appeared on the outside surface below the mucous membrane of the lip; the next day there was a perforation at that point; the wound was and remained dry, had a foul odor and increased steadily in size. From the onset, there seemed to be no pain felt but the child developed diarrhœa.

On arrival at the dispensary, there was found to be a round perforating ulcer in the right lower lip, not crossing the median line, five centimeters in diameter; the edge was moderately dry and covered with a brown slough without any inflammatory margin, the circle was completed by a small flap of lip, the lower right incisors were loose and the gums were brown and soft. The following day the ulcer was the size of a two-cent piece and extended from the angle of the mouth slightly past the median line; all the incisors had fallen out, the maxilla was exposed though covered in part with a necrotic mass; the connecting bridge of lip was broken through so that the ulcer was semicircular; the tongue was moist and slightly coated. Examination of the chest revealed no changes in heart or lungs; the liver extended in the mammary line from the seventh rib to a finger's breadth below the border of the ribs; the spleen,

easily palpable, extended towards the median line of the abdomen to one inch from the umbilicus, and descended to the anterior superior spine; the notch was plainly felt on the anterior margin; the abdomen was somewhat tense and prominent, and except over the liver resonant on percussion. The child was extremely emaciated, there was marked pallor and facies senilis; the epiphyses were enlarged, and there was a well marked rosary.

The clinical diagnosis was "noma, infantile atrophy, rachitis and amyloid degeneration." The case was sent to the hospital for cauterization of the lip, but died within a few hours after arrival.

One culture was made by the writer on gelatin and another on blood serum. Streptococci and bacilli were found in each, but no attempt at identification of the bacteria was made.

Case 2.—Marks Seigel, three years nine months of age, was born in America of Russian parents.

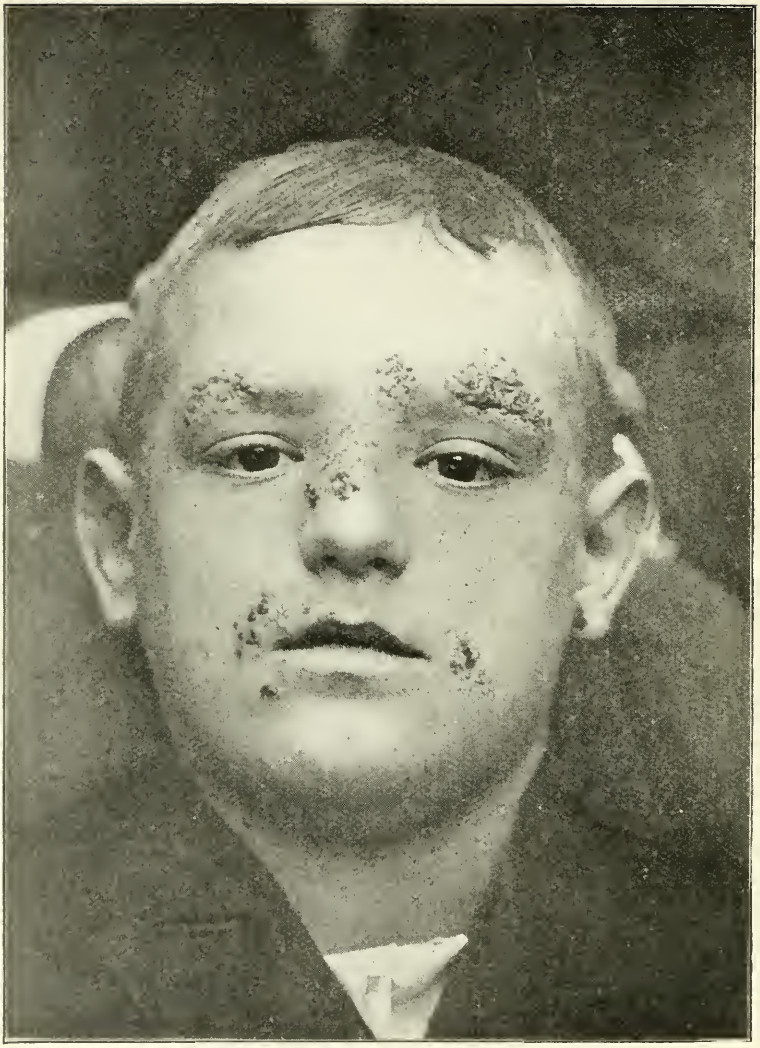
Previous history.—The child was breast-fed and perfectly healthy to the age of three years, when it presented the first symptoms of Pott's disease for which it was later treated by a back brace. Somewhat more than two weeks before admission, the child was taken with measles, but in a few days the rash practically disappeared, and the child was considered well. Ten days after the measles began, the left cheek began to swell, but the child did not cry or seem to suffer. The following day an ulceration was noticed on the inside of the cheek; the next day the ulceration extended to the upper jaw, and there was considerable foul odor from the mouth. On this day the child picked four teeth out of its mouth with its fingers; a day later, the odor was worse, and the child was evidently losing flesh and did not care for food; two days more and the mother noticed upon the cheek at a level with the ala of the nose a dark circular spot about the size of the end of a large lead pencil; in another day the skin over the spot was ulcerated, but there was not complete perforation; more teeth fell out, the swelling of the face was greater, and there was marked prostration and restlessness; the child groaned and kept its right hand in its mouth. The terminal phalanges of the index and second fingers of this hand became inflamed and ulcerated.

On admission, the sixth day from the beginning of the affection, the child was extremely emaciated and in a state of collapse. It was then apparently suffering no pain. The post-cervical glands were enlarged, and a psoas abscess was evident. There was no salivation, and an intense nauseating odor was present about the child. The temperature was 100.4, pulse 170, respiration 138. The child was incontinent of urine and fæces, both cheeks were œdematous and swollen, the eyes were almost closed, and a circular ulcer about the size of a twenty-five-cent piece extended from the angle of the mouth to the ala of the nose and backwards into the cheek; the ulcer was occupied by a slough, and the edges were somewhat indurated. All the teeth but the canine were gone from the left upper jaw, but the lower teeth were present though ulceration extended over the lower gums; the palate was perforated and the nasal cavity exposed. There was a large ulcer on the base and right side of the tongue.

Death followed within 24 hours after arrival at the hospital. During this time the pulse and respiration remained practically constant, but the temperature went up to 102° F.

Forchheimer (American Text Book of the Diseases of Children) says that the predisposing cause is the most important, the immediate cause is still unknown. Of these cases a cachectic condition was present in the first and measles immediately preceded the onset in the second. In 49 out of 98 cases published by Rilliet and Barthez the disease followed measles.

Concerning the rarity of the affection, the following statement is suggestive: Allchin (Keating's Cyclopædia Diseases of Children) says that during seven years in the East London Hospital for Children there were only five cases out of a total number of 6364 admissions, and during thirteen years at the Hospital for Sick Children there were only six cases out of a total admission of 13,000.



Contagious Impetigo.

CONTAGIOUS IMPETIGO.

By William S. Gottheil, M.D.,
New York,
Professor of Dermatology, New York School of Clinical Medicine; Dermatologist to the Lebanon Hospital, and the Westside German and N. W. Dispensaries.

THOSE of us who saw many sick children in New York last summer cannot fail to have been struck with the prevalence of a peculiar eruption affecting the face and hands. The skin clinics, of course, were full of them. Sometimes they came singly, oftener in groups of two or more from one family; occasionally in larger numbers from among the twenty-four families of a single tenement-house; and once, at least, in droves from a single street. We called the malady Impetigo, and as a rule treated it in a very laissez faire manner. For the rational treatment could not be undertaken with any hope of success in this class of patients.

Impetigo is a term that has been greatly abused in the past; and in consequence thereof, was almost banished from our text books. Like so many of the older designations that grew up before even an attempt at a scientific nomenclature was possible it meant various things at various times and in different mouths. Willan, the father of dermatology, called all eruptions characterized by superficial pustules impetigo; whilst the more deeply seated pustular affections were designated as echthyma. Hebra and his followers showed conclusively, however, that the English writer had included under these names different affections and various stages of maladies known by other titles. Both words fell into disrepute and disuse. Nevertheless, there is at least one affection for which the term impetigo is appropriate; and that is the contagious pustular disease described by Tilbury Fox in 1864, as Impetigo Contagiosa, and of which the epidemic cases above mentioned are examples. Its invasion, spread and course are uniform in the extreme, and its individuality is apparent to every observer.

The regular course of Impetigo Contagiosa is as follows: accompanied by more or less fever and gastric disturbance there suddenly appear upon the face and backs of the hands of the child a number of superficial vesicles filled with a semi-

transparent serum. In the beginning they are pinhead-sized and rounded; but as they grow larger they flatten out and their serum turns yellow. When they reach the size of a large pea they begin to dry up, and the flat pustule becomes a circular adherent golden yellow or darker brown crust. Most of the cases that come to us are in this condition. Vesicles and crusts, though they may be grouped, are absolutely discrete, and the skin around them is hardly inflamed. In a few days the crusts fall off, leaving circular reddened areas behind. There is no loss of tissue, and in two to three weeks the redness disappears, and all traces of the disease vanish.

Successive crops of flat pustules may appear on fresh areas of skin, or among the old crusts and prolong the disease for weeks; but each single pustule runs its course in a few days. The face is usually affected first and to a greater degree than the hands.

The malady is eminently contagious, and deserves its name. Children in the same family inoculate one another, and then their playmates. It spreads through schools and tenement-house blocks. During the last summer we saw at the clinic at least fifty cases that came from one tenement-house block in West 53d street. The epidemic that occurred on the Island of Rugen in 1885, is well known.

The etiological factor is undoubtedly a micro-organism. Kaposi claims to have found a special parasite; Geber and Lang believe that they have found the trichophyton, the ringworm parasite in their cases. Cocci of various kinds are always present, but the exact cause of the disease is still unknown. Some have attempted to place impetigo amongst the eczemas; but it does not belong there on account of its contagiousness, regular course, and the absence of the polymorphism so characteristic of the latter disease. Others have claimed that it is a "pemphigus," but a contagious, epidemic, self-limited pemphigus deserves a separate name. It in no way resembles ringworm, and the characteristic parasite has not been found by other observers.

These cases all get well if left to themselves; but it is not well to leave them to themselves, even if the prognosis is good. They spread the disease with their dirty fingers and their tenement-house community of clothing, bed-linen, and towels.

The rational treatment consists, of course, in the removal

of the crusts, and the disinfection and protection of the surface affected. The crusts must be softened with oil compresses, the parts thoroughly cleansed with soap and hot water, and a boric or carbolic acid solution. As a protective dressing, Lassar's paste is as good as anything that we can employ:

℞ Acid. salicyl, gr. 30;
Petrolati, ℥ 1;
Zinci oxidi,
Amyl, āā ℥ ss.

This treatment undoubtedly causes the pustules to heal up quickly; but, unfortunately, we cannot often apply it. It requires a little care and a little intelligence, and of this these people have none to spare. So we do our best, prescribe our ointments, and let the disease spread. Luckily, with the advent of the cold weather, the microbes seem to lose their activity. But a few cases always remain to furnish a starting point for the epidemic of the next summer.

A CASE OF ACUTE INTESTINAL OBSTRUCTION FOLLOWING BRONCHO-PNEUMONIA IN A CHILD TWELVE MONTHS OLD.

By A. Charles Dogge, M.D.,
Helena, Mont.

OLGA H., twelve months old, has been very feeble since birth. The mother nursed the child up to the present time, but also allowed her to partake of food from table. The family are in very poor circumstances, and the surrounding conditions are very unfavorable. The child was taken ill on the 12th day of June, but I did not see her till the evening of June 20th.

When I arrived the child was in a semi-comatose condition. The prostration was very great and the cough severe. Temperature 103° F., pulse feeble, dyspnœa marked, and respiration rapid, 45 to 55 a minute. The cough seemed painful, and was accompanied by muco-purulent expectoration. The face was pale and anxious, the lips blue, the alæ nasi playing with each respiration. A diagnosis of broncho pneumonia was made and an unfavorable prognosis given. The child was put in a bath and then dressed in clean cloths. The room was kept at an even temperature and the air moist. The chest was painted with iodine and enveloped in a cotton jacket. A laxative of calomel and a stimulating expectorant were prescribed. The child rested comfortably during the night, and the next day the dyspnœa was less severe, the temperature lower, and the general condition better.

On June 22 she was conscious, and her general condition was so greatly improved that a favorable prognosis was given. This improvement continued steadily until the next evening, when a slight swelling of the abdomen was noticed. She had a stool after an enema of soap and water, but the abdominal swelling and the tympanites rapidly grew greater, and, in spite of all efforts at relief, she went into collapse and died the next morning at five o'clock.

Autopsy.—Both lungs showed evidences of consolidation. On section, there were small projecting areas of consolidation around the finer bronchioles. The terminal bronchi were filled with purulent material, and certain parts of the lungs were

collapsed, airless and bluish-red. The microscopical examination revealed in the air-cells an exudate which was composed of leucocytes and epithelium; and also an infiltration with leucocytes around the wall of the bronchi.

The stomach was enormously distended with air, and there was an obstruction at the pyloric orifice, as if it had been tied with a band. The intestines contained some fecal matter and were distended with gas. There was a twist of the small intestine and one in the ascending colon. Around each volvulus were about three inches of gut in a greenish condition. The appendix was quite long and green, and contained a small amount of fecal matter. If the child had not been so feeble, an operation may have offered some hope for recovery, but I doubt whether it would have been of any service in this case.

A CASE OF COARCTATION OF THE AORTA—TUBERCLES IN THE CHOROID.

By George Carpenter, M.D.,
London.

PERCY S. M., aet. five years, was brought by his mother to the Evelina Hospital, on June the 10, 1895, with the following history. He had always been delicate and often suffered from bronchitis. At the age of two years he was ill with whooping cough and inflammation of the lungs. Six months ago he had an attack of bronchitis; his cough improved, but he wasted gradually, and his stomach was noticed to be gradually enlarging. The labor was a difficult one, and he was born with "snuffles." At three months of age he had a "gum rash"; the lower extremities, however, were not attacked. He had always been a "chilly" child, but was never noticed to have been cyanosed. The family history was not a satisfactory one. His father and mother had had (one or more) attacks of rheumatic fever, and there was a history of phthisis on the mother's side. Six weeks before the birth of the patient the mother was laid up with influenza and pleurisy. There was no record of any emotional disturbance with the mother whilst carrying. There had been five children of the marriage, one of whom had deceased from "inflammation of the brain" at the age of three years. All of them suffered from "snuffles" at birth, and some of them had rashes, chiefly on the arms and neck, which did not extend below the knees. There had not been any miscarriages, or still-born children. For the last month he had been languid and drowsy, and had declined his food. Some two or three months previous the glands in his neck were discovered to be enlarged.

On Admission.—He was seen to be a badly nourished, ill-developed child, with a pallid face, oral cyanosis, and loud and labored breathing. His temperature at this time, 3 P. M., was 98.2 F., his respirations 36 to the minute, and his pulse, which was feeble, 128 to the minute. On stripping him for examination, what immediately attracted my attention was the enlargement and tortuosity of the vessels about the scapu-

lar and abdominal regions, which will be presently referred to at greater length.

On Examination.—Heart. *The cardiac impulse* was somewhat diffused, but best seen and felt in the fifth interspace in the nipple line, and of a heaving character. Slight epigastric impulse was also detected. *The area of dulness* did not extend to the right, and commenced at the third left costal cartilage. *The sounds* were natural at the apex, but basic systolic bruits were detected on both sides. The murmur was heard rather better on the right side than on the left, and conducted better to the right clavicle than to the left. The bruit was also heard over the right chest behind, and in the right axilla, and detected above the spine of the left scapula. The bruit was not at all striking.

Vascular System.—In the armpits the subscapular and long thoracic arteries were thick, tortuous, and pulsating; the pulsation could be distinctly seen, and the arteries felt very hard. A thick, pulsating vessel, on both sides, could be felt crossing the subclavian triangle; this appeared to be the transverse cervical artery. The superficial cervical artery was enlarged on the left side. In the eighth and ninth interspaces behind, on the left side, enlarged, tortuous, and pulsating vessels could be seen and felt, running from within outwards, and other vessels were noticed crossing the posterior border of the scapula. Similar vessels were seen on the right side, but they were not so well marked, or so much enlarged. The axilliary arteries felt enlarged on both sides, and hard, and they were decidedly tortuous. The brachial arteries felt like whipcord; pulsation was well marked in them and they were slightly tortuous. The radial arteries did not appear to be thickened. A feeble pulse at the wrist was detected in both the radial and ulnar arteries. The superior epigastric and superficial epigastric arteries could be seen pulsating, and felt beneath the skin; the former were decidedly enlarged and tortuous, more so on the left side. The femoral arteries were small, felt like rigid cords, and very feeble pulsation could be detected in them. Feeble pulsation was distinguished in the anterior and posterior tibial arteries. The abdominal aorta could be felt feebly pulsating through the abdominal wall *Per rectum*, a digital examination revealed the following state of affairs: The abdominal aorta could not be felt. Two cord

like structures were distinguished along the brim of the pelvis, one on either side. No pulsation could be obtained in these. The deep epigrastic arteries could be grasped bimanually between the finger in the rectum and that on the abdominal wall, and were found to be enlarged and tortuous. A number of other large vessels could also be felt in the abdominal wall. A collection of enlarged, tortuous vessels was detected in the pelvis, especially in the neighborhood of the sacro-sciatic notch, feeling like a collection of worms, on either side. Running down the front of the sacrum a large and thick vessel was found, and coursing along the posterior wall of the rectum was another enlarged and tortuous vessel.

Lungs.—Both sides of the chest were resonant on percussion. The breath sounds were extra-puerile, and an occasional rhonchus was detected.

Liver.—The free edge of the liver could be felt three-fingers breadth below the costal margin, in the nipple line.

Spleen.—The spleen projected about two fingers breadth in front of the costal margin, and was quite smooth.

Abdomen.—The abdomen was tumid, but, apart from the enlargement of the organs just mentioned, nothing abnormal was discovered.

Urine.—The specific gravity of the urine was 1025, of acid reaction, and contained no albumin or sugar.

Osseous System.—The skull appeared to be thickened. Bossing was detected on the parietal bones in the neighborhood of the coronal suture; the parietal eminences seemed to be normal. The occipital bones appeared thickened, and there was some doubtful thickening of the temporal bones. The teeth were regular and well formed, but several were necrosed.

Cutaneous System.—At the left angle of the mouth there were some linear scars. On the right buttock, near the anus, were two very small circular scars. A small scar was found just below the left patella. The fingers and toes showed a slight tendency to clubbing.

Glandular System.—The glands at the angles of the jaw, in the neck, and in the submaxilliary, and subclavian triangles were enlarged, fairly hard, and freely movable. Below the left mastoid process a large lump of glands, more matted together, could be felt, and a smaller mass on the right side,

in corresponding position, was detected. The glands in the axillæ and groins were not enlarged. The boy had adenoids, and the posterior wall of the pharynx was smeared with mucopus. The tonsils were normal.

Eyes.—An ophthalmoscopical examination was made with practically negative results, for, apart from the possibility of slight enlargement of vessels, nothing abnormal was detected.

Remarks.—My first impression of this case was, that it was one of that very rare malformation, coarctation of the aorta, but the possibility of syphilitic arteritis had to be reckoned with. The age of the child was a point certainly against coarctation, and the thickening of the large arteries in favor of syphilis; but, here again, the distribution was most unusually extensive. Coarctation of the aorta—an excessively rare malformation at any time—is not found out till adult life is reached. When the patient presents himself for heart troubles, a physical examination reveals cardiac enlargement, with possibly a failing heart, and a tolerably accurate opinion can be formed as to the cause of this cardiac enlargement, when with it there is enlargement of, and tortuosity of the abdominal and scapular arteries.

Such an extensive syphilitic arteritis as that described seemed to me quite out of the question, and the vascular condition could be much more rationally explained on the theory that it was due to well nigh empty and contracted arteries. The child was possibly a subject of congenital syphilis, certainly, but, as is well recognized, syphilitic arteritis is extremely rare in congenital syphilitics; moreover, when it does occur, the distribution is focal and local, usually intracranial, and not a general vascular disorder, such as this case presented. With these points in my mind I showed the case to my colleague, Mr. F. Eve, who was of opinion that a small portion of one of the tortuous arteries should be removed for the purpose of microscopical examination as an aid to diagnosis, so as to clear up the question of syphilitic arteritis. Mr. Eve, accordingly, on June the 15th, removed, under chloroform, a small piece of one of the superficial arteries of the abdomen. During the operation the vessel did not pulsate like an artery, the flow of blood being venous both in color and appearance, a fact which caused some comment at the time. When a microscopical examination of the vessel was made, no fault could be

found with it—it had all the appearance of a perfectly healthy artery.

From the time of admission till June the 19th, when a further ophthalmoscopical examination was made, the child had retrograded. His temperature chart showed irregular excursions, and was made of a hectic type. The highest record was 102.4° F., and the lowest 96° F. The highest recorded respirations were 46 to the minute, the lowest 24. The highest pulse was 160 to the minute, the lowest 100. Occasional puffiness of the face and blueness of the lips were seen, the breathing became loud and labored, at times, with occasional coughing; at times he was drowsy by day, and restless by night. On the whole, however, he slept and took his food fairly well. Once or twice he complained of abdominal pain, and on one occasion the abdomen was very distended. A physical examination revealed nothing definite. He required simple enemata from time to time. Although no really definite symptoms made their appearance, he steadily emaciated, and it was thought that an examination of the eyes, a second time, might yield a clue to the downward tendency. The right eye was first examined. A small, but well-marked tubercle was found in the choroid, on the temporal side of the optic disc, and some little distance from it, which was about the size of a big pin's head (indirect), of a light dirty yellow color, the retinal pigment adjoining it giving its margin a worm-eaten appearance. Two other smaller tubercles were detected a little below this one. The optic disc was in an early stage of neuritis. Owing to the extreme restlessness of the child, no clear view of the fundus of the left eye could be obtained, a condition of things which rendered an ophthalmoscopical examination at all a most tedious task. It certainly cleared up the nature of a portion of his malady, and made the diagnosis of general tuberculosis almost a certainty. Most unfortunately one of the nurses in the ward conveyed the result of—or, rather, the opinion formed on—this examination to the relatives of the child, an indiscretion which brought about his removal home by his mother. By this action the verification of the diagnosis has been rendered an impossibility. There is no doubt in my mind—nor do I think there can be any in that of others—that this child's aorta was stenosed, or occluded, below the level of the left subclavian artery. The balance of probability is in

favor of a congenital narrowing of the aorta in the usual situation, though it would perhaps be unwise to overlook the possibility of an acquired stenosis in the same spot, infinitely rare as such a possibility must be, with secondary thrombosis and occulsion. In tubercular mediastinal affections in children such an occulsion occasionally happens in the big veins, and it would be rash to deny that this could happen locally in the aorta. Indeed, the man who denied that any seeming impossibility, or something contrary to one's cherished medical convictions, could occur in medicine would be rash indeed. There was certainly no *evidence* of mediastinal implication, but this, by no means, can be considered to give the mediastinum a clean bill of health. On the whole, however, such an hypothesis is far-fetched, in comparison even with such a rarity as congenital coarctation of the aorta detectable at such an early period of existence, and I believe that if an autopsy had been procurable a congenitally stenosed or occluded aorta, at the point of junction of the ductus arteriosus, would have been discovered. In many cases this coarctation presents the appearance of a linear constriction; sometimes a perforated diaphragm is seen; at others a ligamentous cord is found at the seat of constriction, in which case the vessel is entirely closed at this point. In 24 out of 38 cases of this condition tabulated by Peacock, the duration of life varied between 21 and 50 years.

Fatal Cases of Poisoning with Sorrel Leaves.— Dr. Flemyng records in the *Lancet* two fatal cases of sorrel poisoning, in which two little girls succumbed to the effects of oxalic acid poisoning after eating sorrel leaves. The leaves were eaten in the afternoon of the day previous to that on which the children were brought for treatment, which consisted in the administration of chalk suspended in milk, with lime-water and castor oil. Both died, one eighteen and the other twenty hours after taking the poison. Post-mortem examination revealed no noteworthy appearances except slight congestion of the small intestine in one case. Toxicological examination indicated the presence of a small quantity of oxalic acid in each case. An exploration of the fields which the children visited gave no indication of any poisonous plants but arum and conium, besides the sorrel, and no trace of the two former was found in the stomach.—*Pharm. J., 1896, No. 1357,513.*

PRACTICAL NOTES.

Dispensing Calomel with Sugar of Milk.—For years all of us have dispensed calomel, together with "cane sugar," in the form of powders, and no fault may have ever been found with this combination. Within the last few years it has been found by many of our physicians to be necessary to follow the "progressive line"—that is, to change the "old fashioned" cane sugar to milk sugar, in the case of admixture with calomel, and even with more delicate and more easily decomposable chemicals. "Milk-sugar fame" came from abroad, and we here naturally ape European fashion, whether rightly or wrongly. In my experience calomel and milk sugar, safely enseonced in a good powder paper, as is the common practice among pharmacists, will not keep so long as a mixture of "cane sugar" and calomel, without showing signs of decomposition (turning gray).

This is generally not noticed, because of the large quantity of sugar of milk present, the excess hiding the discoloration; but when, as in my store it is often the case, small amounts of sugar of milk are wanted with calomel, so that the powder can be placed dry upon the tongue or into the mouth of a small child, the metamorphosis of the calomel can be easily noticed before the administration of the dose.—*Drescher Med. Rec., 1896, L, 303.*

A Smallpox Visitation.—The tremendous destruction of life caused by smallpox, previous to the discovery of vaccination, can hardly be realized in our day. The disease was never absent from the chief towns, the victims in London numbering thousands yearly; but it occasionally became epidemic, and was as destructive as was the plague in the seventeenth century or the cholera within living memory. A frightful outbreak occurred in 1758, when one-tenth of the total mortality was due to it. Gloucestershire especially suffered

severely, and in Cirencester the havoc was so great that the neighboring farmers refused to enter the town, and the markets were held in the outskirts. At length, after the scourge had raged for over three months, the following advertisement, signed by the church-wardens, overseers, and high-constables, was published in the *Gloucester Journal*:—" Cirencester, June 27, 1758. Whereas the smallpox is greatly upon the decline in this town, and must in a short time be entirely over, *there being but few people remaining to have it*, this is to give notice that whoever shall presume to bring any person or persons from any distant place or places into this town (not belonging to this parish) having the smallpox, or in order to have it here, shall be prosecuted with the utmost rigour of the law." Similar notices were published by the authorities of Tewkesbury, Winchcombe, and other towns.—*Bristol Med. Chir. Journ.*

A Substitute for Cod-liver Oil.—During the hot season, when cod-liver oil is apt to disagree, the following may be substituted in cases of pulmonary tuberculosis:—

℞ Solution of Potassium Arsenite, ℥ ij
Syrup of the Hypophosphites, ℥ iij.

M. One teaspoonful to be taken thrice daily after food.

Insects' Stings and Bites.—The following may be used to prevent the bites of insects:—

℞ Acetic Ether, 5 parts.
Eucalyptol, 10 parts.
Eau de Cologne, 10 parts.
Tincture of Pyrethrum, 50 parts.

M. Dilute with four or five times its bulk of water and apply as a lotion.—*Practitioner.*

Vinegar as an Antidote to Carbolic Acid.—Applied to the skin or mucous membrane burnt by carbolic acid, vinegar causes a rapid disappearance of the characteristic whiteness as well as the numbness produced by the acid; it also prevents the formation of a slough. Vinegar also neutralises carbolic acid introduced into the stomach. In cases where carbolic acid has been swallowed, therefore, Professor Carleton suggests, the patient should be made to drink vinegar diluted with an equal quantity of water, and the stomach should then be washed out.—*Practitioner.*

Incontinence of Urine.—Dr. H. B. Carpenter has been using the fluid extract of rhus aromatica, with good results, in incontinence of urine in children—giving from 2 to 15 drops three times a day. If the urine is acid and high-colored it is well to begin the treatment by giving an alkaline mixture as follows:

Potassium citrate.....2 drams;
Spirit of nitrous ether.....4 fluidrams;
Simp.....1 fluidounce;
Water sufficient to make.....3 fluidounces.

Dose—Teaspoonful in water every two to three hours.

In nearly all cases it is wise to add tonics, especially strychnine, to the treatment.—*Philadelphia Polyclinic.*

Tracheotomy.—The necessity for performing tracheotomy may arise when the surgeon is unprovided with tracheotomy tubes. Disinfect a fairly large hairpin, and bend both ends at a rather acute angle at about the middle of their length. The ends of the branches may then be twisted into small hooks or rings, to which tapes may be attached. The blunt end of the hairpin is inserted in the trachea, and the branches tied by tapes fastened behind the neck. This will serve until proper tubes can be procured. Failing a hairpin, take a stitch on each side of the opening in the trachea with stout silk, and tie the ends behind the neck. Any piece of iron or copper wire, of suitable size, may serve as well or better than the hairpin.—*Ala. M. & S. Age, Med. Rec., 1896. L, 319.*

Acid Lemonades.—It is well known that acid fluids are very unfavorable to the vitality of the cholera vibrio. Acid lemonades are therefore likely to be to some extent protective, and in any case they can be recommended as agreeable and wholesome beverages during the summer months. The following formulæ may be used:

Citric Acid Lemonade.

Citric acid, ½oz.; the juice and peel (cut small) of two lemons; boiled water, 1 gallon; sugar to taste, ½ lb. To be made fresh every twenty-four hours.

Sulphuric Acid Lemonade.

Made as above, substituting acid sulphuric dil., 1 oz., for the citric acid. Syrup of lemons or orange, 1 pint; boiled water, 4 gallons; dilute sulphuric acid, 2 ozs.

Nitric Acid Lemonade.

With 1 oz., dilute nitric acid instead of citric acid.—*Practitioner.*

Editorial.

FAN VENTILATION AS A LIFE-SAVING MEASURE.

The torrid weather of the first half of August, covering the whole of the Central and Eastern United States, was the cause of much suffering and many deaths. It is to be noted, however, that the infant death rate in New York City was conspicuously small. This remarkable fact must be attributed to recent advances in pediatric practice, especially as regards infant-feeding and the abuse of drugs, and to improved municipal sanitation. In spite of this encouraging feature, it is unquestionable that many infants and young children paid sad tribute to the destroyer. Injurious effects were observed not only in increased susceptibility to the usual summer diseases, but dangerous prostration and lowering of the vital forces, without special digestive disturbance, were not rare.

It was in such a case that Dr. James S. Brown, of Montclair, New Jersey, advised the use of an electric fan for its refreshing and tonic effect. A nine-inch fan, operated by four large galvanic cells, was quickly installed, and the alleviation was prompt and decided. It is Dr. Brown's opinion that the child would not have survived the hot spell without the relief thus afforded. Other instances have been reported to the writer in which strikingly favorable effects were observed from fan ventilation. In one instance a lady prostrated from heart disease was, by the unanimous testimony of the family, enabled to survive the summer only by the supporting effects of the air currents from an electric fan. When the fan was started, her restlessness would often disappear and she would drop off into refreshing sleep. A New York firm in the electric business claims to have received many letters testifying to the saving of life during the past summer by the use of fans.

It is evident that a fan of sufficient power will purify and cool the air of a sick-room, banish flies, and soothe and refresh

the patient suffering from the depressing effects of prolonged heat, and lighten the labor of attendance. Battery fans can now be had at a reasonable price, which will run 125 hours without recharging, and which can be started and stopped at will.

In conclusion, it would appear that this practical sanatory means should not be restricted to private practice, but that fans of proper capacity should be installed in dispensary rooms and in hospital wards, where they could readily be operated by the dynamo-electric currents in general use.

HENRY LING TAYLOR, M.D., New York.

Abstracts.

PATHOGNOMONIC SIGNS OF CONGENITAL SYPHILIS.

P. Silex (*Berliner clinish Wochenschr, 1896, xxxiii, 139*). The following is taken from an address delivered before the Berlin Med. Gesellschaft:

The author recognizes three characteristic signs of congenital syphilis. The first relates to the eyes, the second to the teeth, and the third to the skin. As the only real pathognomonic symptom relating to the eyes, he mentions chorioidea areolaris, in which are found, scattered over the fundus particularly in the neighborhood of the macula, black points and patches, which present here and there white spots of different size and larger areas with a black border. These represent atrophic colonies in the chorioidea, and pigment patches derived from the pigment of the stroma and pigment epithelium. The retina also being involved vision in these cases is always very much impaired. Mercurial inunctions and exhibition of potassium iodide effected no change. In a few cases, the process, which is rare, remained unilateral. Of the numerous deformities of the teeth usually mentioned, S. only considers that one form pathognomonic, where the permanent upper incisors present a central excavation, denuded of enamel, beginning on the surface for mastication, and continuing upward in the shape of a crescent. As a sign which is only found in congenital syphilis, he considers the well-known scars radiating outward in straight lines, which do not confine themselves to the corners of the mouth or to the lips, but radiate further to cheek and chin. The histological examination of a case which was particularly marked, proved that these lines are not scars in the anatomical sense, as papillæ, glands, and vessels were well preserved in the tissue under consideration. Very likely the peculiar furrow-like appearances, which are called pseudo-scars by S., are due to a muscular tension of the skin. These three kind of conditions which were demonstrated by the author both on the subject and through illustrations, are considered by him absolutely pathognomonic. So that the presence of even one of them will lead to a positive diagnosis of congenital syphilis.

TREATMENT OF PERITYPHLITIS IN CHILDHOOD.

A. Schlossmann (*Münch med. Wochenschr, 1895, 41—Archiv. für Kinderheilk, 3 and 4, 263*). The main points in medicinal treatment are the same in children as in adults. The author deprecates the use of laxatives and clysters in the early stage of the disease, as they may hasten the danger of perforation of the vermiform process, and advocates perfect immobility of the gut, an indication which is best covered by the enforcement of absolute rest in bed, ice applications, iced fluid food, and the administration of opiates. Regarding the dose of opium, one need not be anxious on account of its usual danger to children, as it is according to experience very well borne in all the inflammatory conditions of the peritoneum. It is impossible to fix the dose, but it should be given according to tolerance, which can only be measured by the behavior of the pulse and the pupils under its influence. In cases where vomiting is a prominent symptom, the narcotic should be administered in some iced fluid, or by means of suppositories. At the conclusion of the article, the author mentions the surgical treatment of this disease, and confesses that an early use of the knife meets with his approval.

RESULTS OF THE PATHOLOGIC ANATOMICAL EXAMINATIONS OF THE EAR IN MEASLES.

F. Bezold (*Kinderarzt, 1896, vii, 80*) after carefully conducted examinations for a number of years arrives at the following practically important conclusions: In not one case of death from measles was there missing at the autopsy a mucopurulent or purulent secretion in the temporal bones. With the exception of one case, where the process existed before the contraction of measles there were present fresh inflammatory processes, confined in one case only, to the bony tube, in two to the tube and the floor of the tympanum. In all other cases there were collections of secretions, redness, and swelling covering all the cavities of the middle ear. A spontaneous perforation of the drum membrane is not often produced by the otitis of measles. Injection of the vessels was slight, irregularly distributed and occasionally punctiform. The destruction of the drum membrane and the auditory canal occur very seldom, probably on account of the more protracted course of the

inflammation, than we find in other forms of otitis, notably that occurring with scarlet fever. The otitis of measles is to be looked upon as an integral part of the systemic infection, and does not arise through extension from the nose into the Eustachian tubes, etc. In the greater number of cases the pus is again absorbed without having caused perforation of the membrane, or any injury even to the hearing. In a few cases the exterior of the drum membrane does not show any changes, but usually it is somewhat darker, and particularly in the posterior upper quadrant of a diffuse livid red color. Masses of pus may shine through in the intermediary zone of the posterior half, giving it a yellowish color, and usually it is slightly bulging here. Besides this, single radiating vessels are frequently seen, and in single cases a sinking of the drum membrane is observed. The surface becomes successively dimmer, often wrinkled, and on greater saturation by serum or thin liquid pus, raised vesicles are noticed. If a perforation takes place from the middle ear, the secretion will continue days or weeks. The perforation is seldom large, and always closes up again. With good treatment, hearing is restored even in the perforative form. In comparison with the forms of otitis which complicate other infectious diseases, the one appearing with measles is to be considered of a relatively mild character.

CONTRIBUTION TO THE ETIOLOGY OF RETENTION OF URINE.

W. Knopfelmacher (*Centralbl. f. Kinderhkde, 1896, i, 1–24*). Only few etiological factors are usually given in the reports on the retention of urine in children. Biedert recognizes only one—ischuria spastica; Teevan only three mechanical causes—congenital stricture of the meatus, phimosis, and stone. English mentions (1) Abnormal developments and defects. (2) Congenital narrowing of the urethra. (3) Ridges formed by the mucous membrane of the urethra. (4) Excess of uric acid, gravel, and stone. (5) Inflammatory processes of the kidneys, the bladder, the prostate gland, the urethra, the foreskin (oftentimes due to smegma, to periprostatitis, and pericystitis, originating from the vessels of the navel, or from coxitis). (6) Retention cysts in the follicles of the urethra, closure of the sinus pocularis in boys, swelling of the papillæ. 7) Changes in the prostate (congenital hypertrophies). (8)

Foreign bodies and growths in the urinary organs. Bokái adds: (9) Sagging of the mucous membrane of the bladder, (10) Strictures. (11) Local atony and paresis of the bladder. (12) Stupor in infectious diseases. (13) Diseases of the brain and spinal cord.

It is remarkable that in this etiological enumeration, there is an absence of just that group, which in adults so frequently causes retention of urine, viz.: neoplasms in the neighboring organs. The following observation will prove that even in infants this etiological cause must be taken into consideration.

A child aged 9 months was brought to the clinic with the history of a continued fever rising to 40° C., of having had no passage for some weeks, and had not passed water for 40 hours. Examination revealed an evenly distended abdomen and in the median line over the symphyses an oval, elastic tumor, which reached to the umbilicus—the distended bladder. Percussion was dull over the region of the bladder and in both flanks; over the rest of the abdomen percussion was very tympanitic; no fluctuation was felt. Normal dulness of liver and spleen was much diminished on account of the presence of meteorism. The urine was turbid, slightly ammoniacal, contained a small quantity of albumin, and many pus cells were found in its sediment. Catheterization was easy. The finger was easily introduced into the rectum, but when passed backward came in contact with great resistance, which seemed to fill the whole pelvis, and encroached so far on the symphysis pubis, that the finger could just be moved within the rectum. On pressing upward fecal masses were felt. Believing the retention to be due to an accumulation of fecal matter, and its pressure through the rectum, a high irrigation of the bowel with water and oil was ordered. The child then passed a little urine, but the bladder could not be fully emptied. After the child had been in the hospital four days, the fever continuing, and other symptoms remaining unchanged, it died. An autopsy revealed, besides a pyelonephritis suppurativa acuta, the presence of a tumor which was of the size and shape of a hen's egg, attached to the lower sacral vertebra and pressing the rectum forward, at the same time compressing it and the neck of the bladder. The extraordinarily congested, dark red swelling proved to be a round-celled sarcoma of the sacrum.

This case is not an isolated one. There is on record the case of H. Smith, in which a fibroid of the pelvis caused retention of urine in a child 19 months old, and another by Jones, of a 12 year old boy, caused by a lymphadenoma of the lesser pelvis. The reason that tumors of the pelvis do not more frequently cause retention is, probably, because tumors found in this region (the pelvis), and which are always congenital in infants, have a tendency to grow outwards. To complete the etiology of retention in children, two more causes must be cited: the atresia hymenalis, where the accumulation of secretions may produce compression of the urethra, and the tumors of the sexual organs in girls, for example, the polyp sarcomas of the vagina, which produce retention partly from compression of the urethra, and partly by extension onto the urethra or wall of the bladder.

A CASE OF SYPHILIS HEREDITARIA TARDA.

Hunicken (*Deutsche med. Wochenschr, 1896, xxii, 46*) reports a case of knee-joint disease with accompanying periosteal irritation of both tibiæ, whose character was only so readily discovered because H. fortunately knew the history of both parents. The mother of the now 9 year old boy had been infected by her husband about ten years ago, in the second month of pregnancy, and could only be freed from spyhilitic symptoms after a treatment of six weeks by mercurial inunctions, and the internal exhibition of iodide of potassium. The robust woman was delivered at the normal end of gestation, of a small, but otherwise perfectly healthy boy, who throve exceedingly well at the breast and presented no suspicious symptoms whatever. He learned to walk before he was two years of age, and bore the operation of vaccination well, which had been postponed to his third year by Dr. H. as a precaution, because H. had repeatedly had the experience, that any latent disease germ in the child mignt very easily be developed through the process of vaccination and its accompanying fever period. With the exception of an attack of croupous pneumonia in his sixth year, the boy was never ill. Now, however, in his tenth year, he began to complain in the beginning of February, of pain in both knees, at first only on walking, but later both knee joints became swollen, and gradually took on pretty large dimensions, without any other changes. After three weeks of

this swelling, there appeared periostitic pains which were notably increased on pressure over both tibiæ. The diagnosis of probable congenital syphilis which was made was substantiated by the success of the antisyphilitic treatment instituted. Inunction of mercurial ointment daily (1 grm.) for four weeks, and the internal use of potassium iodide for eight weeks (daily dose ½ grm.) removed the knee-joint disease as well as the periostitic pains absolutely.

H. does not believe that in this case there could have been an acute stage of syphilis, which, according to Baumler, may pass unrecognized during the first year of life, as the child had been under constant observation by the parents as well as by himself. But another point made by Baumler was confirmed in this case, namely, that the symptoms of hereditary syphilis which make their appearance at the time of the second dentition or at puberty, are symmetrical, attacking both halves of the body. Only that in this case there is no question of a relapse, but it constituted the first symptom of a hereditary syphilis.

MELÆNA TRAUMATICA.

R. Langerhans (*Centralbl. f. Kinderheilk, 1896, i, 27*). Preuschen believes in two forms of melæna neonatorum: The one includes seemingly healthy children who are attacked with bleeding from the mouth or anus soon after birth or during the first days of life; the other includes all those children who show well-marked symptoms of a general disease (sepsis, etc.), do not have hemorrhages before the 8th or 11th day after birth, and who show at the autopsy hemorrhagic changes in different organs; in this group the hemorrhages from mouth or rectum constitute only the symptom of a hereditary or acquired hemorrhagic diathesis. The first group is only to be considered as coming under the head of "Melæna vera." The cause of the latter he believes to be injuries to the membranes of the brain and to the brain itself during birth, particularly in those cases complicated with hemorrhage. Experimental studies prove these rules of experience, as they proved that gastro-enteric hemorrhages may be caused by changes of the brain. The connection between the bleeding from the gastro-intestinal canal (also pulmonary hemorrhages) with changes, notably injuries of the brain, has been already known, but was never so positively asserted. Now L. has also contributed a case to this

question. A child born out of wedlock on February 12, 1895, was said to have had twitchings of the left leg and arm on March 21st. On the following day it was admitted to the Krankenhaus, where the child, which was much atrophied, and had a subnormal temperature had occasional twitchings of the left side of the face and the left arm and leg. No external injuries whatever could be discovered. Death occurred March 25th. Section disclosed a hemorrhagic infiltration of the pericranium, an abundant intermeningeal hemorrhage, and a fissure of the left parietal bone; along the whole gastro-intestinal tract there were found numerous dark masses, which were partly of a bright red and partly of a dark brown color. All the internal organs were very anæmic. One may well class this case with the melæna vera. Certainly the trauma did not exist from birth (opposed to this was the freshness of the extravasation), but was of a later period, and though the mother's actions were rather suspicious, nothing could be proved against her. L. maintains that an external injury must have been inflicted. The absence of any injury to the soft parts does not militate against this fact, for only lately Erle has published three cases where, after a heavy blow, fissures occurred, without the least visible external evidence. The death of the child was in consequence of the hemorrhage. The intermeningeal hemorrhage had probably already occurred before the child was admitted to the hospital (twitchings on the day previous).

The hemorrhage of the stomach, however, took place later, as it was not in evidence during life. The subnormal temperature before death, and the great anæmia of all internal organs found at the autopsy, indicate that the copious hemorrhage of the stomach should be taken into account in judging of the cause of death, along with the pressure on the brain which must have been produced by the large intermeningeal hemorrhage. There was no question of sepsis, syphilis, hemophilia, etc., in this case; nor was there present an acute infectious disease. It was undoubtedly a case to be added to Preuscher's melæna vera. However, this author claims that the hemorrhage should follow immediately after birth, while in this case it made its appearance after five weeks, and was not produced by any injury during birth, but later. L. would like to have the word vera, which really belongs to all forms of melæna, discarded, and would call all cases of melæna, which are caused by an injury—malæna traumatica.

A CASE OF SARCOMA OF THE CÆCUM.

John Homans (*Annals of Surg., 1896, xxiv, 42*) reports a case with the following history: Until January, 1896, the child had been extraordinarily well and strong and was the picture of robust health. She suddenly complained of abdominal pain and began to emaciate rapidly. A physician, without making any physical examination, pronounced the case one of dyspepsia, but pain continued and emaciation progressed rapidly. The appetite, however, continued excellent, almost ravenous. At length a movable tumor in the abdomen was made out. She was pale and thin. Her morning temperature had been 99.3° F., and at evening 103.2° F. There was a movable solid tumor about the size of a sheep's kidney in the appendicular region. There was very slight tenderness on pressure. The diagnosis was uncertain. After etherization, the child was placed in the Trendelenburg position, and the tumor was found to have left the cæcal region and to have gone almost to the epigastrium. As the tumor could easily be brought to the median line, an incision was made three and a half inches long in the linea alba between the umbilicus and pubes.

The tumor was found to be a sarcoma and to involve a portion of the anterior wall of the cæcum. About half a pint of ascitic fluid ran out. The tumor, a flattened sphere two and a half inches long, was somewhat adherent to the ileum, and had grown not only into the wall of the cæcum but also into the ileo-cæcal valve. A solid rubber cord was tied round the intestines above and below the growth and the tumor, with about an inch of the anterior wall of the cæcum and a portion of the ileo-cæcal valve, was removed. A solid piece of fæces lodged in the cæcum was taken out, the parts were douched with boiled water, and the opening in the cæcum, left by the removal of the growth, was sewn up with two rows of continuous Lembert sutures of silk. The sewn-up bowel was given a final douching, after the removal of the constricting rubber cord, and was then returned to the abdomen. A small wick of iodoform gauze was laid upon the seam in the cæcum, and the end was left protruding out of the wound, which was then sewn up with silkworm gut. Iodoform gauze, absorbent cotton, and a swathe were put on. An enema of four drops of laudanum and a drachm of brandy was given.

Dr. Whitney's report is as follows: "The tumor of the cæcum from a girl, five years old, consisted of a more or less lobulated mass the size of a large potato, pale, grayish, and slightly translucent on section with a homogeneous surface. To this was intimately adherent a portion of the bowel, the walls in places being infiltrated from without inward by the new growth. Microscopic examination showed its structure to be made up of small spindle cells with a little homogeneous intercellular substance, and with the blood circulating in sinuses without definite walls. The diagnosis is a spindle-cell sarcoma, which has originated in the tissue about the intestine."

The patient had more or less pain for a few days, relieved by enemas of liquid Dover's powder. The wound united by first intention, the gauze was removed on the second day, and the patient went home at the end of three weeks. From the nature of the growth a recurrence seems very probable, but is not by any means certain.

THROMBOSIS OF THE SUPERIOR MESENTERIC VEIN.

At the Medical Society of Victoria, Dr. C. H. Mollison showed this specimen removed from a boy 11 years old, admitted to the Children's Hospital suffering from ascites and hæmatemesis. Tapping was resorted to, but the fluid soon re-accumulated. An exploratory laparotomy was also performed, but without much result. At the autopsy, a considerable amount of clear fluid was found in the peritoneal cavity, the spleen was greatly enlarged, and was unduly attached to the diaphragm by firm, fibrous adhesions. The stomach was also adherent to the under surface of the liver, and the lesser omentum was greatly thickened. The portal fissure was occupied by firm, fibrous tissue, which extended some way into the substance of the liver. The portal vein was contracted, while a large, pale, adherent thrombus occupied the upper portion of the superior mesenteric vein; that portion of the vein below the obstruction being considerably dilated. There were also some ante-mortem thrombi in some of the branches of the splenic vein within the organ. The splenic substance was very firm and fleshy. The liver was smooth and much increased in consistence. The kidneys were intensely tough, though smooth on the surface. Sections showed marked thickening of the

fibrous framework of the liver, kidneys, and lungs, with hypertrophy of the coats of the vessels. The disease was regarded as a manifestation of congenital syphilis.—*Intercolonial Medical Journal of Australasia, Vol. I, p. 318.*

A CASE OF BARLOW'S DISEASE.

G. Liebe (*Münch med. Wochenschr., 1896, xliii., 30*) relates the history of his own child, which, without having shown the least signs of rhachitis, living in the best possible hygienic surroundings, was taken ill with true scorbutus (bleeding of the gums, enlargement of the glands, and red macules similar to contusions covering the limbs and nates, general malaise and severe chill). There was no cause to be found but this, that the child, though over two years of age, was put on Soxhlet's sterilized milk of three-quarters of an hour's sterilization. The use of simply boiled milk, and the giving of fruit and fruit juices in plenty, produced a rapid cure, with the exception that the submaxillary swellings remained, in spite of linseed meal poultices, for many months.

THE PRODUCTION OF ILL-HEALTH AND DEATH BY THE USE OF CARBOLIC ACID AND ALLIED ANTISEPTICS.

Von Stuhlen (*Kinderarzt, 1896, vii, 42*) draws the following conclusions from his investigations of the subject:

1. The use of carbolic acid and allied disinfectants are responsible for shattered health and deaths, but more often is death produced than serious chronic illness.

2. Most accidents are due to carelessness, usually through the careless setting away of the poison, so that a mistake is easily made by exchanging it for other medicines or liquids.

3. Medical poisonings occur very seldom, and when they do occur are usually due to the use of solutions of too great strength.

4. Children and weakly persons are very susceptible to the poisonous actions of antiseptics, particularly to carbolic acid poisoning, and in these patients it is possible that the usual strength of the solution may produce bad effects.

5. The application of carbolic acid to mucous membranes in large quantity is very dangerous, on account of the rapid

absorption which takes place—above all is the use of carbolic acid, even in small quantities, dangerous as an injection.

6. It is well to be somewhat sceptical as to the absolute immunity from poisoning by the newer antiseptics. There is no absolute proof that they are perfectly harmless; in fact, a few cases of accidents have already happened through them. They are, however, as a rule, much less dangerous than carbolic acid.

7. The autopsies in cases of poisoning by the above mentioned antiseptics were not very satisfactory.

OBSERVATIONS ON INTESTINAL INVAGINATION IN CHILDREN.

H. Hirschsprung (*Archiv. f. Kinderheilk, 1896, xx. 3 and 4. 258*) has observed 64 cases of intestinal invagination in children during a term of 21 years. Of these 46 were boys and 18 girls. Sixty-four were under one year of age, nine under two years. Recovery took place in 38 cases—60 per cent. Of the 11 cases of invaginatio ileo-colica, not one recovered. The other 53 cases were invaginations of the large intestine (invagin. ileo-cœcalis and invag. coli). The kind most usually met with is the invag. ileo-cœcalis. The disease begins suddenly with pain and vomiting. There may be, perhaps, one more natural passage, but then frequent stools of mucus mixed with blood, without much tenesmus, succeed. Vomiting and pain usually cease within 24 to 36 hours, the child becomes somnolent, and it goes into a condition resembling shock. On the left side can be felt, usually without an anæsthetic, a large, thick swelling, which surrounds the navel, and whose convexity is towards the left. Sometimes the tumor can be felt through the rectum. Seldom is the swelling felt on the right side of the navel; the iliac fossa is always free. Invaginatio coli usually attacks children over one year of age. The complaint does not usually appear in perfectly healthy children. Diarrhœas may have preceded it. A disposition to constipation is frequently present. The disease itself begins suddenly, with severe pain. In one-half of the cases a symptom is referred to which is not met with in any other form of invagination—this is the *repeated passing of a clear mucus*. The tumor lies to the left, in accordance with

the seat of the disease, in the descending colon, and the sigmoid flexure.

The invaginatio ilei and the invaginatio ileo-colica can not be distinguished clinically. The cases of H. all occurred in children under nine months. Invaginations of the small intestine usually come on suddenly. The discharges of bloody mucus are of less amount than in the invaginations of the large intestine. The swelling, in contrast to the latter, is difficult to discover, because it is rather small in invagination of the small intestine; and is usually to be found on the *right* side. Treatment depends on the differential diagnosis of the two conditions. In recent cases where the swelling is easily approached, it is proper to try reposition by the use of massage; sometimes this may be accomplished. If it prove unsuccessful, the child should be chloroformed, and enemata of water should be tried. One thousand to two thousand cc.m of water may be forced into the gut with moderate pressure. Whether reposition has been accomplished can only be told in a few hours, when fecal matter has found its way to the rectum, and the swelling has definitely disappeared. In the interval the child should receive a proper dose of opium.

If the enema has been of no service, which can be known by the persistence of the tumor, and the passing of bloody mucus in large quantity, after the evacuation of the water, the operation should certainly be repeated in a positive case of invagination of the colon.

In cases of invagination of the small intestine, an operation is at once indicated.

CONTRIBUTION TO THE CAUSATION AND THE STATISTICS OF PRIMARY TUMORS OF THE BLADDER IN CHILDHOOD.

Steinmetz (*Deutsche Zeitschr. f. Chirurgie, 1896, xxxix, 313–336*), in connection with a case of primary sarcoma of the urinary bladder, occurring in a boy 2¾ years of age, who was seen at the Münchener chirurgische universitaets clinic, and where also an autopsy was obtained, collates the published cases of primary tumors of the bladder up to the present time, which occurred in childhood. He was able to gather only 32

cases, including his own, thereby proving the rarity of the affection in early life. In 30 cases, where the sex was mentioned, 20 cases were males, and 10 females; so that also in childhood, as in adult life, the male sex seems to be prominently predisposed to this affection. As regards the age of the patients, children during the first five years of life are most frequently attacked. In 29 cases, where the ages were recorded, there were 23 cases during the first five years of life (including one newly-born) and only six cases between the 5th and 13th year.

All the tumors belonged to the class of connective tissue tumors. Fourteen (one case was a myosarcoma) were sarcomas. Thirteen are designated as myxoma, but the author, in conjunction with Albarran and Fennick, is inclined to believe that also these were probably sarcomata or myxosarcomata (most of these tumors having been diagnosticated according to their macroscopic appearance); so that the sarcoma must be looked upon as the predominating variety, found in the bladder of children. Besides these there are recorded, one fibromyoma, one cystofibroid, one rhabdomyoma, and two other tumors, which were not classified. In two of the cases there were present congenital deformities of the urinary organs, namely, one diverticulum of the bladder, and, in the author's case, one horse-shoe kidney. The seat of the tumors was electively the location at the neck of the bladder, and its lower third, through which may be explained why frequently dilatation of the ureters and hydronephrosis, with implication of the kidney (pyelonephritis) was observed. Quite frequently (as in the author's case) a part of the tumor protruded into the urethra, and in females through the urethra into the vulva. Of 26 cases only one presented a solid tumor; in one case there were two tumors, but in all others there presented more usually a great number. Nearly always cystitis and hypertrophy of the muscular wall of the bladder was present, which latter fact might be of diagnostic importance on bimanual examination of the empty bladder. Metastases are only mentioned in one case, a lymphatic gland of the size of a hazel nut being found at the lower end of the left ureter.

The course of the disease in the child differs in so far essentially from that of the adult, inasmuch as hematuria, which usually appears very early, is seldom found in the child (only

four cases of hematuria are mentioned, in two of which it occurred at the very end, probably caused by the intense cystitis). More frequently the affection is announced in children by difficult urination,—strangury, anuria, symptoms of stone, pain in the bladder and glans penis, causing the patient often to continually pull at the organ. Prognosis, as a rule, is absolutely fatal. Within ten weeks to three months from the first symptoms death is induced by infection (cystitis, pyelonephritis) and uremia (hydronephrosis), in only one case, published by v. Linhart, the duration of the disease covered a period of two years. Operations were performed in 15 cases. One case only, operated on by Billroth and published by Gussenbauer, which proved to be a solitary pedunculated myosarcoma was successful. It may be that the prognosis in the future will become somewhat more encouraging, if an early diagnosis would lead to an earlier operation. It should be borne in mind, in this connection, that Albarran has often found a hematuria in tumors of the bladder which only could be recognized by a microscopical examination of the urine.

ON GONORRHŒA IN LITTLE GIRLS.

Cassel (*Archiv. f. Kinderheilk, xx, 3 and 4, 238*), made a close study of the pathogenesis of this disease in thirty little girls, who were suffering from a vulvo-vaginitis. The examination for gonococci were made according to Gram: staining with methylviolet, afterwards with Bismark-brown. It proved that no less than 24 of the patients were suffering from true gonorrhœa. The ages of the children were respectively, one year, seven months, another one year, six were two years, four from two to three years, six three years, one four and three-quarter years, one five years, three from six to seven years, one eight years and one eleven years of age. As regards the cause of the infection, in ten cases none could be found. In one case infection through a brother, 18 years of age, was probable; in one oxyuris vermicularis was given as the cause by the parents, however no parasite could be discovered. In three cases, the mothers of the girls were suffering from a puriform discharge. Of the single cases, only four are of etiological interest. In three the infection was due to the father—after the puerperum of the mother the children became infected. In a

fourth case the infection came from the father direct. In four more cases, some other member of the household was the carrier—brother, bedfellow, sister (puella publica). As to the method of infection, it is probable that it was usually carried by soiled body linen, etc. The symptoms were always, discharge of greenish yellow pus from the genitals. In 19 cases pus could be squeezed out of the urethra and the vulva; only in three cases was the vulva covered with puriform membrane. The hymen was intact in all of the cases. The course of the disease ran variable. In a few cases the discharge ceased very slowly; in others it disappeared in a few days. Of other complications there were observed, two cases of connective tissue inflammation, which in both cases took a favorable course. Unfortunately treatment could only be carried to the end in eight cases, owing to the indolence and carelessness of of the patients.

Local treatment is usually difficult, because the anatomical conditions in the child do not permit of every kind of local application. Above all, the source of infection should be made inocuous, furthermore, absolutely clean under-clothing should be insisted on, the eyes are to be protected and the genitals frequently cleansed; which can be done by injecting medicated solutions into the vagina, by means of a rubber bulb syringe. The child should lie on its back, with extended legs, and a pillow under the sacrum during this procedure. Before using the injection the vulva is to be washed out with clean water. The liquid used for injecting may consist of a solution of corrosive sublimate (½ pro mille), later a nitrate of silver solution (1–1½ pro mille) may be used. In the six cases where the gonococci were absent, the clinical symptoms also were different. The discharge in these cases was a thin, greyish secretion. The treatment of this non-infectious inflammation is the same, only stronger astringents should be used.

BELLADONNA IN THE TREATMENT OF EPILEPSY.

Féré (*Centralbl. f. d. g. Therapie, 1896, xiv, 158*) has again given this drug, which had been already lauded by Debreym one hundred years ago, and since then by Trousseau, a trial. The latter administered it first in enuresis nocturna, and then tried it in epilepsy. He began by giving one

pill (1 cgr. Extr. and 1 cgr. pulv. bellad.) three times a day, gradually increasing the dose every month up to toleration, and occasionally reaching the dose of 20 pills a day. In case of amelioration the doses were reduced in the same way, and, when possible, he discontinued the medication for a time. Trousseau and Pidoux recommend the use of the neutral sulphate or valerianate of atropia—(½ mgr. in children, 1–2 mgr. for adults). Hughling Jackson believes that the dose should be increased until dryness of the throat is experienced, and that the drug should be given in the evening, as he thinks it has an elective affinity for the nocturnal attacks. Pierret lauds maximum doses, of 8 cgr. for the vertigo and mental symptoms of epilepsy.

Féré orders the belladonna in the form of an extract in pills, the dose being 2 cgr., and increases it every 3–4 weeks only. He was able to reach the enormous dose of 76–80 cgr. by this plan. He observed, though, that intolerance may be suddenly established by any great excitement. This treatment, which was employed in patients who had been refractory to other remedies, has only been of temporary benefit. Out of 24 individuals who took daily doses of 12–25 cgr., seven were benefitted slightly; only in one case was the result a thoroughly satisfactory one. This patient was subject to irresistible impulses, and exceedingly numerous attacks of vertigo (344 in a month). From January, 1893, to the end of July, 1893, he took a daily dose of 8–20 cgr. of extract of belladonna, and then had only about 195 attacks of vertigo a month. From August, 1893, to the end of April, 1894, during which time he took 20–30 cgr., the attacks were reduced to 26 a month. During the month of April, he had only four attacks, and since then only slight aura. The patient is still taking 30 cgr. a month.

TUBERCULOSIS IN EARLY INFANCY.

H. Kossel (*Der Kinderarzt, 1896, VII, 19*) had the opportunity of observing 22 children, of the ages of two months to three years, during their illness with tuberculosis. All of these cases ended fatally. There was also found in 14 children, who died from other causes, at the ages from one and one half to 10 years, on autopsy, tubercular foci situated in 10 cases in the bronchial glands, and in one case involving the

mesenteric glands, which had not manifested any symptoms during life. Amongst the anatomical findings in these cases, the changes in the respiratory tract and its lymphatics, were undoubtedly the foremost, and in second line those of the digestive tract. The latter were found to be primary tuberculosis; in one child, 8 months old, was found a tubercular ulcer of the ileum, and a tubercular infection of the mesenteric glands.

The observations made in numerous cases of extensive tubercular processes in infants only a few months old, seems to permit the question, whether an infection with tubercle bacilli may not have been possible during intrauterine life. This question is not only of scientific interest, but also of great practical importance.

The author thinks it noteworthy, as militating against infection before birth, that he never found older tubercular foci in the liver into whose circulation all germs that are being carried say by the veins of the navel, must pass first. Moreover, these foci were always found in the lungs, or in those glandular environments whose main roots were nearest in connection with the outer world—i. e. the bronchial glands, or mesenteric glands. The author comes to the conclusion that in tuberculosis of early infancy, at least, we have to admit an infection with the disease germ, in the first few months following birth, by contact. It is quite obvious that infants whose parents expectorate the infectious germs of tuberculosis in large quantities, are very likely to admit tubercle bacilli by way of the respiratory system, or the digestive organs, into the economy. In course of the investigation the sad discovery was made, that among the children from one to ten years of age, who were sent to the institution (usually for diphtheria), 40 per cent. were suffering from latent tuberculosis. Does it not seem about time, says the author, to follow the lead of the Americans, and employ practical measures against the spread of tuberculosis.

INFLUENZA IN CHILDHOOD.

A. Schlossmann (*Allg. medic. central ztg.*, *lxiv*, *1033*). Although the infant possesses a certain power of resistance against this disease, as well as against the contraction of other infectious disorders, there is no immunity for any period of

life. The youngest patient seen was 21 days old, it, as well as its mother, was suffering from this disease. Much more frequently children during the second half of their first year of life were attacked, and no seeming difference exists in their liability to its contraction between this time and later years.

The younger the child the greater the difference of the symptoms from those considered characteristic in the adult. While the so called gastric form of influenza marks the exception to the rule in later years, and alterations in the mucous membrane of the respiratory tract take a more active form, in the young infant the main symptoms relate to the gastro-intestinal canal. The advent of the disease in young infants might be called explosive, without any prodromal state, or catarrhal antecedants. The illness begins with all the signs of a heavy infection, with rapidly rising temperature, even with chills, vomiting, delirium and convulsions. An exceeding prostration is established at once, not at all in proportion to the duration and height of the fever, but very characteristic of the disease under consideration. Changes in the lung tissue could not be demonstrated in most cases. Besides fever, which may rise to the height of 40.5 C on the first day there is anorexia, and as a typical initial symptom, great constipation of a few days duration. A coated tongue, and reddened pharynx usually completes the picture of these cases. A characteristic symptom is the redening of the pharynx, which is not present in those cases we are used to classify under the name of gastric fever. The diagnosis is to be made from the sudden epidemic appearance of these symptoms, while a great number of cases of catarrhal influenza are found in older children. Besides, a causal relationship of the disease can frequently be proven, the adults as well as the children of one family being stricken at the same time, the former with the usual restriction of the local symptoms to the respiratory organs, while the latter are more subject to gastric symptoms. It has also frequently been observed that a seemingly simple coryza (an influenza) was carried over by the adult to the child, and produced in the latter a severe general infection. Another diagnostic point between the simple gastric disorders and those due to influenza, are the accompanying pains in the limbs, which are recognized by the crying of the child whenever it is moved or picked up.

Particularly is any pressure on the epiphysis of the long bones resented with marked exhibition of discomfort.

The obstinate constipation, which is an initial symptom, gives place to a diarrhœal state on the third day, even though no cathartics be given, which may last a longer or shorter time, with exacerbations and remissions. The stools are frequently very fœtid and mixed with shreds of mucus. Author is inclined to the belief that this diarrhœa is the result of toxin poisoning, that it is produced by the influenza bacilli, which primarily attacks the pharynx, where they produce the inflammatory redness alluded to previously. In most cases the fever soon disappears, and rapid convalescence is the rule. In others the gastric symptoms may continue for some time in the form of a more or less profuse diarrhœa, and the whole attack may cover a longer period, with continuance of the fever. If at the same time an enlargement of the spleen is also present, the idea of typhoid fever may easily occur to one. In these cases we have a pretty positive differential mark; the diazo-reaction of the urine, which, being very characteristic in typhoid fever, is absent in influenza. We may sometimes, on shaking the urine with the well-known re-agents, get a red color of the foam, but it does not show the daily deepening of the color, which is found in the early stage of typhoid fever. Next to typhoid, scarlet fever had often to be differentiated, as there occurred an eruption in 12 per cent. of the cases, which sometimes rapidly disappeared, at others remained permanent for a while. These exanthemata were frequently similar to the eruption of scarlatina, at other times they resembled miliaria. The face usually remained free, but the rest of the body may be covered? The symptom complex was occasionally so similar to scarlet fever, that the patient was treated as regards isolation and disinfection as though he had scarlet fever, until the course of the disease established its character. A symptom, based on the infection of the pharynx, seemed to be helpful in differentiating the two diseases. The throat, in case of scarlet fever, is usually of a deep scarlet color, when the eruption is at its height, or there are already deposits present on the mucous membrane of the throat; at the same time the neighboring glands become enlarged. All these symptoms are absent in influenza, and the redness of the throat will be found more diffuse and less intense.

When brain symptoms are very prominent—influenza may also simulate diseases of the meninges. In the case of a boy, there developed uncontrollable vomiting, severe headache, a degree of opisthotonos and irregularity of the pulse and respiration, with a rapid and alarming failure of strength that called for energetic stimulation. The boy developed a form of psychosis, which occasionally rose to mania, from which he suffered for three weeks. It is very easy to imagine in such cases that some hemorrhagic process has taken place in the brain, as was proved, post-mortem, in a number of cases ending fatally, by Kranhals and others. Another deep impression on the nervous system could be frequently demonstrated in the heart action, which showed, under sphygmographic tracings, irregularities, and often the greatest arythmia, as are usually only seen, as a rule, in diphtheria.

The complications involving the kidneys are of some importance. In eight per cent. there was albuminuria of different degrees and duration. In three per cent. it was severe, and accompanied by casts, usually much cylindrical epithelium and quite some epithelial débris in the stage of fatty degeneration. The number of blood corpuscles was small.

As regards the condition of the joints, there was severe pain and swelling of the shoulder and elbow-joint, the left arm and then the knee joint, in one case. Retrocession was rapid and spontaneous. Pain alone, without any changes in the joints, is a part of the history of this disease. The lungs, which are usually affected in the adult, seem to remain altogether free from any inflammatory process in young children, in others, a bronchitis occasionally followed the gastric symptoms, in which frequently slight spots of consolidation could be diagnosed by means of auscultation, and the duration of the fever. In three cases a pneumonia of considerable extension, with effusion into the pleura was observed; but it was not possible to demonstrate any micro-organism in the fluid through culture. The prognosis in influenza of children was considered much better than in old people.

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